TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Trenton D. Weeks, D.C.

Respondent Name
Ascension Health

MFDR Tracking Number
M4-15-3695-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Previous MMI certification does not negate the injured employee's entitlement to subsequent MMI/IR evaluations by certified doctor… The injured employee had completed all recommended treatment with good improvement …, thus requiring an alternative MMI/IR evaluation requested by treating doctor."

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dr. Weeks' evaluation is not subject to reimbursement … as an alternative MMI / IR evaluation because the designated doctor's certification was not the first certification and a treating doctor had already provided an MMI / IR certification."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 5, 2014	Referral Doctor Examination to Determine MMI/IR	$650.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.0041 sets out requirements for Designated Doctor Examinations.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 50 – These are non-covered services because this is not deemed a medical necessity by the payer.
   - 216 – Based on the findings of a review organization.

- PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary.
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.
- OA – The amount adjusted is due to bundling or unbundling of services.

Issues

1. Were the disputed services performed in accordance with Texas Labor Code §408.0041?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor argues that they are providing an alternate maximum medical improvement and impairment rating in accordance with Texas Labor Code §408.0041 (f-2), which states,

   > An employee required to be examined by a designated doctor may request a medical examination to determine maximum medical improvement and the employee's impairment rating from the treating doctor or from another doctor to whom the employee is referred by the treating doctor if:
   >
   > (1) the designated doctor's opinion is the employee's first evaluation of maximum medical improvement and impairment rating; and
   >
   > (2) the employee is not satisfied with the designated doctor's opinion.

   Review of the submitted documentation finds that the first evaluation of maximum medical improvement and impairment rating was not from a designated doctor, but from the treating doctor. Therefore, the disputed services were not performed in accordance with Texas Labor Code §408.0041.

2. The requestor has not established entitlement to reimbursement in accordance with applicable guidelines. Therefore, no reimbursement is recommended.

Conclusion

While not all evidence was discussed, it was considered. For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	October 9, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.